MEDICARE PRESCRIPTION DRUG BENEFIT

Background

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), established the Medicare Prescription Drug Program, also known as Medicare Part D, making prescription drug coverage available to Medicare beneficiaries. The new program goes into effect January 1, 2006. The MMA also provides extra help (a subsidy) with prescription drug costs for eligible individuals whose income and resources are limited. This help takes the form of subsidies paid by the Federal government to the drug plan in which the Medicare beneficiary enrolls. The subsidy provides assistance with the premium, deductible and co-payments of the program. Beneficiaries may apply for the Low-Income Subsidy (LIS) with SSA starting in May 2005 or with their State Medicaid agency starting in July 2005.

Medicare beneficiaries who wish to enroll in the Medicare Prescription Drug Program must choose a prescription drug plan through which to receive the benefit. There is an initial open enrollment period from November 15, 2005 through May 15, 2006, during which beneficiaries can enroll in a plan. There will be subsequent enrollment periods for the Medicare Prescription Drug Program each year.

Generally, coverage for the drug benefit will be provided by private prescription drug plans (PDPs) that offer drug-only coverage, or through Medicare health plans that offer both prescription drug and health care coverage (known as MA-PDs). Both types of plans must offer a standard drug benefit, but will have the flexibility to vary the drug benefit. Covered Part D drugs are essentially the same drugs and biologicals that are approved for the Medicaid program (although selection may be restricted through a plan's formulary) and they must be dispensed by prescription and on an outpatient basis. Drugs and biological products that are paid for by Medicare Part A or B are excluded.

What the MMA Requires of States

The new law requires both Social Security and the States to accept and process applications for the low-income subsidy (LIS). The law also requires States to screen subsidy applicants for eligibility for the Medicare Saving Programs (Qualified Medicare Beneficiary [QMB], Specified Low-Income Medicare Beneficiary [SLMB], and Qualified Individual [QI]). Specifically, States are required to:

- Provide the Center for Medicare and Medicaid Services (CMS) with data on subsidy-eligible individuals residing in the State.

- Provide information to all inquirers on the nature of, and eligibility requirements for, the Medicare Part D low-income subsidies.

- Assist subsidy applicants with completion of the SSA subsidy application and transmit the application to SSA.

- Screen all subsidy applicants for the Medicare Saving Programs (QMB, SLMB, QI) eligibility and offer enrollment to applicants who qualify.

- Make subsidy eligibility determinations for applicants who request a State determination.

- Notify subsidy applicants and recipients of the outcome of the initial and subsequent subsidy determinations made by the State.

- Grant an opportunity for appeal to any subsidy applicant/recipient whose eligibility was determined by the State.

- Redetermine subsidy eligibility at least yearly for individuals whose subsidy determination was made by the State.

Federal financial participation (FFP) is available for these activities.

Who Must Apply

Beneficiaries with limited income and resources who do not fall into one of the deemed subsidy groups must apply for the low-income subsidy. Their eligibility for subsidy assistance can be determined by either the Social Security Administration (SSA) or the State agency that determines Medicaid eligibility (the local department of social services).

For beneficiaries who apply for the subsidy, the income of the applicant and that of their spouse who resides with the applicant will be counted. Once counted, income will be compared to the federal poverty level standard applicable to the size of the applicant's family to determine eligibility. Family size includes the applicant, the spouse residing with the applicant, if any, and the number of individuals who are related to the applicant or spouse, who are living in the applicant's household, and who depend on the applicant or spouse for at least one half of their financial support.

Resources (assets) are considered in determining eligibility for a subsidy. Resources that will be considered in determining eligibility generally include liquid resources that can be readily converted to cash within 20 days (e.g., checking and savings accounts). Also countable is real property that is not the applicant's primary residence and not attached to the primary residence. The resources of the applicant and their spouse, if any, will be counted to determine if the applicant meets the resource threshold to be eligible for a Part D low-income subsidy. Resources of dependent family members are not counted for the applicant and their spouse. If dependent family members are Medicare beneficiaries

themselves, they must file their own subsidy application or be deemed eligible in their own right.

Resource Standards

The maximum subsidy resource standards are $10,000 for one person and $20,000 for a couple. Resources at or below $6,000 for an individual and $9,000 for a couple and income at or below 135% of the Federal Poverty Level ($12,920 single/$17,321 couple) will entitle the applicant(s) to the full subsidy.

Who Doesn't Have to Apply (Deemed Eligibles)

Certain groups of Medicare beneficiaries will automatically qualify for the low-income subsidy. These groups are deemed eligible for the subsidy for calendar year 2006. The following groups are deemed eligible:

- Full-benefit dual eligibles who are persons eligible for both Medicare and full Medicaid.
- Supplemental Security Income (SSI) recipients, including SSI recipients who receive a cash benefit but not Medicaid.
- Medicare beneficiaries who are participants in the Medicare Saving Programs (MSP), which are QMB, SLMB, and QI.

Deemed eligibles do not need to file an application for the subsidy. CMS will automatically award them the subsidy based on information received from the States and SSA and notify them that they are eligible without having to file an application. They do, however, need to choose a prescription drug plan. If they fail to choose a plan, the full-benefit dual eligibles will be autoenrolled by CMS in a plan by December 31, 2005. QMBs, SLMBs, QIs and SSI recipients will be autoenrolled in a plan by May 31, 2006 if they do not choose a plan on their own.

How to Apply

Many Medicare beneficiaries must file an application for the Low-Income Subsidy. The exceptions are individuals deemed eligible for the subsidy (see above). Individuals who must file may do so by contacting:

- SSA-- by mail, by telephone, on the Internet, or in person.

- Their State's Medicaid agency.

IMPORTANT: The selection of a drug plan and application for the subsidy are separate processes which do not substitute for each other. For individuals who must apply for the subsidy, selection of a drug plan is crucial.